STATE OF KANSAS
DEPARTMENT FOR CHILDREN AND FAMILIES
ECONOMIC & EMPLOYMENT SERVICES

MEDICAL ASSISTANCE LIEN
PHYSICIAN VERIFICATION

ES-3152
10-04

PART I. INSTITUTIONALIZED PERSON'S IDENTIFICATION

1. Last Name	First	Middle	Date
Medicaid Card ID Number	Social Security Number	Birthdate	
2. Name of Facility		Telephone Number	
Address:			

PART II. STATEMENT OF ATTENDING PHYSICIAN

1. Is it reasonable to expect that the above-referenced person will be discharged from the long term care setting and return home?

☐ Yes; the person can be expected to return home, estimated period of care _____

☐ No; the person cannot be expected to return home.

2. The medical reasons for this expectation are:

_____

_____

_____

_____

_____

I certify that I am the attending physician of the above referenced person and that the statements I have made herein concerning this person are based on my professional assessment of his/her medical condition and are supported by the person's medical record.

Signature of Physician	Printed Name of Physician			Date
Address	City	State	Zip	Telephone

ATTENTION PHYSICIAN: Please return this form to the following:

_____

_____

_____

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